

# **PROOF OF CLAIM**

**FOR LIQUIDATOR'S USE ONLY**

## **THE PROTECTIVE NATIONAL INSURANCE COMPANY OF OMAHA**

**Deadline: February 12, 2005**

CLAIM NO.:

DATE RECEIVED:

Complete All Sections

Please print or type

1. Claimant's Name: \_\_\_\_\_
2. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
3. Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email address: \_\_\_\_\_
4. Claimant's Social Security Number or Employer ID Number: \_\_\_\_\_
5. Name of Insured: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
(If you have claims under more than one policy, you must file a separate Proof of Claim for each policy)  
Date of Loss: \_\_\_\_\_
6. Claim is submitted by (check one):  
☐ Policyholder – Claim by insured of a policy issued by Protective National  
☐ Third Party Claim – Liability claim against an insured of a policy issued by Protective National  
☐ Cedent/Reinsured – Claim by an insurer which ceded risks for reinsurance by Protective National  
☐ Reinsurer – Claim by an insurer which has assumed risks from Protective National  
☐ Other Creditor or Claimant
7. Describe the facts that establish your claim. Attach separate pages if necessary. If written documentation substantiates your claim, attach copies of such documents. If the basis for your Claim is a Judgment against Protective National or an insured of Protective National, attach a certified copy of the Judgment to this Claim.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Amount of Claim: \$ \_\_\_\_\_
9. If the Claim is CONTINGENT as to entitlement or amount, describe all contingencies: \_\_\_\_\_  
\_\_\_\_\_
10. Is this Claim covered by other insurance? YES ( ) NO ( )  
If YES, state the name(s) of the insurer(s) and the policy number(s): \_\_\_\_\_  
\_\_\_\_\_
11. Has legal action been instituted by anyone regarding this Claim? YES ( ) NO ( )  
If YES, state the following: Court where filed: \_\_\_\_\_  
Docket Number: \_\_\_\_\_ Date Filed: \_\_\_\_\_  
Plaintiff(s): \_\_\_\_\_  
Defendant(s): \_\_\_\_\_
12. If represented by an attorney, please supply the following information:  
Name: \_\_\_\_\_  
Firm: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

***If your name or address  
change, you must notify  
the Liquidator so he can  
advise you of new  
information.***

Your attorney may receive copies of the Reports filed by the Liquidator with the Liquidation Court by filing a Service Request in the Liquidation Proceedings and serving a copy on William R. Kutilek, Crosby Guenzel LLP, 134 South 13<sup>th</sup> Street, Suite 400, Lincoln, NE 68508, Telephone: 402-434-7300

Under penalty of perjury, the undersigned subscribes and affirms the following: that the undersigned possesses the right and authority to sign and submit this Proof of Claim; that the undersigned has read the foregoing Proof of Claim and knows the contents thereof; that the contents of the foregoing Proof of Claim are true and accurate to the undersigned's best knowledge and belief; that no payment of or on account of the foregoing claim has been made, except as otherwise stated above; that there are no offsets or counterclaims thereto, except as otherwise stated above; and that the undersigned is not a secured creditor of Protective National and has no security interest, except as otherwise stated above.

If the foregoing Proof of Claim alleges a claim against an insured of Protective National (Third-Party Claim), the undersigned hereby releases any and all claims which have been or could be made against such insured of Protective National based upon or arising out of the facts supporting the above Proof of Claim up to the amount of the applicable policy limit and subject to coverage being accepted by the Liquidator, regardless of whether any compensation is actually paid to the undersigned.

\_\_\_\_\_  
Claimant's signature

\_\_\_\_\_  
Date